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	344003	A. BUILDING _____ B. WING _____	C 12/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HOSPITAL	201 STEVENS MILL ROAD GOLDSBORO, NC 27530

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A 400	489.20(l) COMPLIANCE WITH §489.24 The provider agrees, in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on police log reviews,staff and physician interviews and policy reviews and medical record reviews, the hospital failed to comply with 42 CFR 489.24. The Findings include: ~Cross refer to Appropriate Medical Screening Exam, Tag A406, Standard 489.24(a)(1)(i).	A 400		
A 402	489.20(q) POSTING OF SIGNS The provider agrees, in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, observations, and staff interviews,	A 402		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 402	Continued From page 1 the facility failed to ensure that signage specifying the rights of individuals with emergency medical conditions was posted conspicuously in the Admissions Office area (the portal of entry) for those persons presenting for emergency psychiatric or medical care per facility policy. The findings include; Review of the current facility policy "EMTALA Requirements and Reporting of Suspected Violations" effective 2-1-02 revealed "3. Signs (in English and Spanish) will be conspicuously posted in the admitting offices of (name of Hospital): -specifying the rights of individuals with respect to examination and treatment for emergency medical conditions; and -indicating that (Name of Hospital) participates in the Medicaid program (Title XIX)." Tour of the Admissions Office area on 12/6/2005 at 1500 revealed the English version of the EMTALA signage was posted on the opposite wall of the reception window at the front door (entrance breeze way) of the office. The same tour revealed that the Patient and Visitor Waiting Areas (2 separate areas one for Adults and one for Adolescents) had no signage posted specifying the rights of individuals making a request for a possible emergency medical condition. Additionally, no Spanish version of the EMTALA signage was noted to have been posted anywhere in the Admissions Office Area. During an interview with the Admissions Unit Nurse Manager and the Nursing Services Director on 12/6/2005 at approximately 1515 they stated, "We have the Spanish version. It just has not been posted since we moved over here one	A 402		

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A 402	Continued From page 2 month ago." They further stated they do have patients who speak Spanish as a primary language who come in for admission to the facility. The interviews confirmed the patients and families wait in the two waiting areas and there was no signage available in either area.	A 402		
A 404	489.20(r)(2) and 489.24(j)(1-2) ON CALL PHYSICIANS §489.20(r)(2) The hospital (including both the transferring and receiving hospitals), must maintain a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule	A 404		

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A 404	Continued From page 3	A 404		

elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties.

This STANDARD is not met as evidenced by:
Based on police log reviews,staff and physician interviews and policy reviews the physician on call failed to complete a medical screening examination (MSE) on an individual presenting and to the Screening/Admissions area requesting help for a possible Emergency Medical Condition (EMC) in 1 of 22 patients sampled. (# 8).

The Findings include:

Review of the Hospital A's police call log revealed documentation on 11-24-05 between 0700 and 1900 a hospital police officer transported an "Ex PT", name of Patient # 8 and Identification number, to hospital B. The transport was from "Admissions". Further review revealed officer # 1 transported the patient at 1536 to hospital B's ER.

Telephone interview with officer # 1(officer for hospital A) on 12-6-05 at 1215 revealed the officer had been called to Admissions to transport a patient to hospital B's ER on 11-24-05. The interview revealed the officer was aware an individual had walked in from the "street" asking for help. The individual was a previous patient that needed to go to hospital B's ER. When the officer arrived at Admissions the individual was in the waiting area and told the officer he needed help. The officer did not receive any report of information regarding the patient or the patient's complaint. The interview revealed the officer "dropped" the patient off outside the ER at hospital B. During the transport the patient was "talking in and out" switching thoughts. The

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A 404	Continued From page 4	A 404		

officer "assumed" the patient went into the ER because he had seen hospital B's police officer coming out to the drop off area. The interview revealed there was no communication to hospital B that the officer was transporting a patient to the ER. The interview indicated hospital B's police officer may have heard a transmission over a "scanner system"about the transport. The interview revealed the officer did not have communication with hospital B about the patient, transport or receipt of the patient.

Telephone interview with Health Care Technician (HCT) #1 on 12-7-05 at 1100 revealed the HCT worked on 11-24-05 from 1500 until 2300. The interview revealed "all" patients that present to the Admissions area are evaluated by a physician whether the patient is a walk in, voluntary or involuntary commitment. The interview revealed at approximately 1515 Patient # 8 walked in on 11-24-05 asking for help. Since the HCT knew the patient, the old medical record was pulled. The HCT noted the patient was documented as incompetent so the HCT called the physician on call (Physician # 1). The HCT told the physician that the patient was in the Admissions area and was documented as incompetent from previous records. The physician told the HCT to send the patient to Hospital B's ER. The interview revealed no vital signs were assessed and no physician assessed the patient before the patient went to Hospital B's ER. The interview revealed the HCT did not give any information to the physician regarding the patient's psychiatric status at presentation. The HCT called for Hospital A's police to transport the patient. The interview revealed the HCT did not communicate to Hospital B that the patient was being transported in by police. The interview revealed

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the patient did return later in the shift as an involuntary commitment and the patient was admitted.

Telephone interview with Physician # 1 on 12-7-05 at 1130 revealed the physician was on call for 11-24-05. The physician was called about a patient walk in requesting help. The patient (Patient # 8)was known to the physician from a previous hospitalization. The interview revealed the staff informed the physician that the patient was incompetent. The interview revealed the physician did not complete a MSE for the patient. The interview revealed the physician told the staff to send the patient to Hospital B's ER. The interview revealed the staff did not report any status of the patient to the physician. The interview revealed the physician had not had training in EMTALA requirements. The interview revealed the reason that he had not completed a MSE on the patient was because he was on call for two consecutive days and the patient would need two examinations within 24 hours by different physicians.

Review of the current hospital policy "EMTALA requirements and Reporting of Suspected Violations" effective 2-1-02 revealed that Hospital A will maintain and establish compliance with the EMTALA regulations by: "1. Will not refuse to examine or treat medically unstable persons who presents to the Admitting office. 2. Shall provide an appropriate medical screening examination to an individual regardless of diagnosis, financial status, race, color, national origin or handicap." Further review of the policy revealed the definition of Emergency Medical Contrition was "a medical condition with acute symptoms (including severe pain. psychiatric disturbances, and/or symptoms

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A 404	Continued From page 6 of substance abuse) so severe that the absence of immediate medical attention could" result in placing the individual's health in serous jeopardy, serious impairment to a body function or organ. Continued review revealed "7. If an individual comes to the admitting office and requests an examination or a request is made on the individuals's behalf, (Name of Hospital A) will provide an appropriate Medical Screening Examination, within our capability, to determine whether or not an emergency medical contrition exists. Review of the Screening/Admissions Office policy manual effective March 6, 2005 revealed under voluntary admissions "1. Any individual, or his appropriate representative Regardless of whether nor not he/she was referred and authorized by the local mental health program, may request evaluation or voluntary admission to (Name of Hospital A). 2. The individual is evaluated by the examining physician in Screening/Admissions Office to determine whether or not admission is justified. 3. The examining physician completes an assessment." Interview with administrative staff on 12-7-05 at 1230 revealed the hospital did not have a policy addressing when the on call physician was on call for two consecutive days what the physician was to do when patients were "walk ins".	A 404		
A 406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this	A 406		

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section, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction.

If an emergency medical condition is determined to exist, the hospital must provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.

If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

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This STANDARD is not met as evidenced by:
Based on police log reviews,staff and physician interviews, policy reviews, and medical record reviews the physician failed to complete a medical screening examination (MSE) on an individual presenting to the Screening/Admissions area requesting help for a possible Emergency Medical Condition (EMC) in 1 of 22 patients sampled. (# 8).

The findings include:

Review of the Hospital A's police call log revealed documentation on 11-24-05 between 0700 and 1900 a hospital police officer transported an "Ex PT", name of Patient # 8 and Identification number, to hospital B. The transport was from "Admissions". Further review revealed officer # 1 transported the patient at 1536 to hospital B's ER.

Telephone interview with officer # 1 (officer for hospital A) on 12-6-05 at 1215 revealed the officer had been called to Admissions to transport a patient to hospital B's ER on 11-24-05. The interview revealed the officer was aware an individual had walked in from the "street" asking for help. The individual was a previous patient that needed to go to hospital B's ER. When the officer arrived at Admissions, the individual was in the waiting area and told the officer he needed help. The officer did not receive any report of information regarding the patient or the patient's complaint. The interview revealed the officer "dropped" the patient off outside the ER at hospital B. During the transport the patient was "talking in and out" switching thoughts. The

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officer "assumed" the patient went into the ER because he had seen hospital B's police officer coming out to the drop off area. The interview revealed there was no communication to hospital B that the officer was transporting a patient to the ER. The interview indicated hospital B's police officer may have heard a transmission over a "scanner system"about the transport. The interview revealed the officer did not have communication with hospital B about the patient, transport, or receipt of the patient.

Telephone interview with Health Care Technician (HCT) #1 on 12-7-05 at 1100 revealed the HCT worked on 11-24-05 from 1500 until 2300. The interview revealed "all" patients that present to the Admissions area are evaluated by a physician whether the patient is a walk in, voluntary, or involuntary commitment. The interview revealed at approximately 1515 Patient # 8 walked in on 11-24-05 asking for help. Since the HCT knew the patient, the old medical record was pulled. The HCT noted the patient was documented as incompetent so the HCT called the physician on call (Physician # 1). The HCT told the physician that the patient was in the Admissions area and was documented as incompetent from previous records. The physician told the HCT to send the patient to Hospital B's ER. The interview revealed no vital signs were assessed and no physician assessed the patient before the patient went to Hospital B's ER. The interview revealed the HCT did not give any information to the physician regarding the patient's psychiatric status at presentation. The HCT called for Hospital A's police to transport the patient. The interview revealed the HCT did not communicate to Hospital B that the patient was being transported in by police. The interview revealed

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the patient did return later in the shift as an involuntary commitment and the patient was admitted.

Telephone interview with Physician # 1 on 12-7-05 at 1130 revealed the physician was on call for 11-24-05. The physician was called about a patient walk in requesting help. The patient (Patient # 8)was known to the physician from a previous hospitalization. The interview revealed the staff informed the physician that the patient was incompetent. The interview revealed the physician did not complete a MSE for the patient. The interview revealed the physician told the staff to send the patient to Hospital B's ER. The interview revealed the staff did not report any status of the patient to the physician. The interview revealed the physician had not had training in EMTALA requirements. The interview revealed the reason that he had not completed a MSE on the patient was because he was on call for two consecutive days and the patient would need two examinations within 24 hours by different physicians.

Review of the current hospital policy "EMTALA requirements and Reporting of Suspected Violations" effective 2-1-02 revealed that Hospital A will maintain and establish compliance with the EMTALA regulations by: "1. Will not refuse to examine or treat medically unstable persons who presents to the Admitting office. 2. Shall provide an appropriate medical screening examination to an individual regardless of diagnosis, financial status, race, color, national origin or handicap." Further review of the policy revealed the definition of Emergency Medical Condition was "a medical condition with acute symptoms (including severe pain. psychiatric disturbances, and/or symptoms

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of substance abuse) so severe that the absence of immediate medical attention could "result in placing the individual's health in serous jeopardy, serious impairment to a body function or organ. Continued review revealed, "7. If an individual comes to the admitting office and requests an examination or a request is made on the individuals's behalf, (Name of Hospital A) will provide an appropriate Medical Screening Examination, within our capability, to determine whether or not an emergency medical contrition exists.

Review of the Screening/Admissions Office policy manual effective March 6, 2005 revealed under voluntary admissions "1. Any individual, or his appropriate representative Regardless of whether nor not he/she was referred and authorized by the local mental health program, may request evaluation or voluntary admission to (Name of Hospital A). 2. The individual is evaluated by the examining physician in Screening/Admissions Office to determine whether or not admission is justified. 3. The examining physician completes an assessment."

Medical record review of Patient # 8, a 53 year old patient, (at Hospital B transferring hospital) revealed the patient presented to the Dedicated Emergency Department (DED) at hospital B on 11-24-05 at 1604. Record review revealed the patient arrived ambulatory and alone. The patient presented with a chief complaint "I'm suicidal, have no place to live, no family." Review of the triage assessment revealed pulse 119, blood pressure 94/79 and pain rated a 9 out of 10. The patient was observed laughing and talking to self. Record review revealed at 1758 "Pt reports he went to XXX (Name of hospital B) this afternoon

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and told them he was suicidal and he was going to kill himself. Pt reports that the person at Hospital B told him he was just homeless and he need to go to the ER to get checked out by a Dr." Review of the MSE revealed the patient had suicidal ideation. Record review revealed the patient was involuntarily committed because the patient was "mentally ill and dangerous to self ." Record review revealed the patient was transferred to hospital A (psychiatric hospital) on 11-24-05 at 1837 with a diagnosis of schizophrenia undifferentiated and not currently on medication.

Medical record review of Patient # 8 at Hospital A revealed the patient presented to the Screening/Admissions area on 11-24-05 at 1855. Review of the MSE revealed the patient had evidence of looseness of association, unable to give any significant history due to pressured speech and thought disorder. Record review revealed the patient was admitted to the hospital with a diagnosis of schizophrenia, undifferentiated type. Review of the physician's admission orders revealed the patient was to be monitored every 15 minutes.